

NOTICE OF INDEPENDENT REVIEW DECISION

June 27, 2002

RE: MDR Tracking #: M2-02-0772-01
IRO Certificate #: 4326

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to ___ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination, and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 49 year old female sustained an injury to her back on ___ when she slipped at work, fell on her back and hit her right hip on the door. She complains of low back pain. The patient is receiving chiropractic care from ___ and he has recommended that the patient undergo a chronic pain management program for 20 sessions.

Requested Service(s)

Chronic pain management program for 20 sessions

Decision

It is determined that the chronic pain management program for 20 sessions is medically necessary to treat this patient's condition.

Rationale/Basis for Decision

Based on a whole person impairment rating of 23% by the designated doctor along with supportive notes, the patient is severely disabled from the accident. Psychological testing reveals personal and emotional difficulties relating to her disability. Functional

capacity examinations indicate that she will be unable to return to full time duties. TWCC spinal guidelines recommend that treatment programs include, if indicated, behavior pain management, mental health interventions, and chronic pain management for patients in the tertiary phase of care. Participation in the chronic pain management program will afford this patient the opportunity to return to gainful employment and therefore, the program is medically indicated.

This decision by the IRO is deemed to be a TWCC decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

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If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

Sincerely,